

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN1916</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/13/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>GREENHILLS HEALTH AND REHABILITATION CENTE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>3939 HILLSBORO CIRCLE</b> <b>NASHVILLE, TN 37215</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments  Complaint investigation # 35340 was completed at Green Hills Health and Rehabilitation Center on January 13, 2015. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE